TEXAS Health and Human Services

ICF/IID Augmentative Communication Device (ACD) System Authorization

Form 8728
December 2009

Is this submission a request to transfer the authorization of an ACD System to a new provider? ..... ☐ **Yes** ☐ **No**

(If **Yes**, complete **only Sections A, B and F** and submit the form.)

Section A: Resident-Related Identifying Information

Resident's Name	Resident's Medicaid No.	Date of Birth	Is resident age 21 or older? ☐ **Yes** ☐ **No**
Resident's Address	City, State, ZIP Code		
Resident's Legally Authorized Representative (LAR) Name		Resident's LAR Telephone No.	
Resident's LAR Address	City, State, ZIP Code		

Section B: ICF/IID Provider Identifying Information

Provider Name	Provider HHSC Contract No.	Provider NPI No.
Provider Address	City, State, ZIP Code	
Provider Primary Contact Name and Position	Provider Telephone No.	Provider Fax No.

Section C: Licensed Speech Therapist Identifying Information and ACD Assessment

Therapist's Name and Title	Therapist's Telephone No.	Therapist's Fax No.
Employed by the ICF/IID Provider? ☐ **Yes** ☐ **No**	Therapist's Employer Name	
Mailing Address	City, State, ZIP Code	

ACD Assessment (Completed by Therapist)

I. Diagnosis (DX) Relevant to the need for the ACD System

Item No.	ICD-9 Code	Brief Description	Medically Necessary (MN) Justification for the Item(s)
1			
2			
3			
4			
5			

II. Resident Auditory Functionality Status Statement

Give a detailed statement describing what the resident's current level of auditory functioning is (aided and unaided).

III. Description and Name of Specific ACD System Recommended

A. Give the name and a complete description of the ACD system being recommended, including all components (must include manufacturer's name and ACD model number).

Resident Name:

B. Describe all accessories, mounting devices and/or modifications necessary for the resident's use.

C. Describe any anticipated changes, modifications or upgrades the ACD system will require, with projected time frames (short and long term).

D. Provide information about alternative ACD systems that were considered for recommendation with a comparison of capabilities.

E. Describe other types of equipment that will be used in conjunction with the ACD system (for example, wheelchair, walker, etc.).

F. Explain how the ACD system will be operated (for example, hand, chin, etc.).

IV. Description of How the ACD System Will Meet the Specific Needs of the Resident

A. Explain the justification for the recommended ACD system and each accessory, including why the recommended ACD system is the most appropriate, least costly alternative and how it will benefit the resident.

B. Provide a description of the practical limitations of the resident's current aided and unaided modes of communication.

C. Describe the cognitive skills and physical abilities of the resident to be able to use the recommended ACD system.

Resident Name:

V. Description of Specific Training Needs for Use of the ACD System (including resident, staff and family)

A. Describe the settings (for example. residential, vocational, educational, etc.) in which the person will be using the ACD system and how much time is spent in each setting.

B. Explain how the ACD system will be implemented and integrated into the above settings.

C. Provide a treatment plan (in the space provided or attached separately) that includes training in the basic operation of the ACD system to ensure optimal use by the resident and, if appropriate, the resident's caregiver, including a therapy schedule for the resident to gain proficiency in using the ACD system.

D. Explain the resident's speech-language goals and how the recommended ACD system will assist in achieving the goals.

E. Identify all assistance/support needed and available to the resident to use and maintain the ACD system.

F. Indicate if a therapist from the educational/vocational setting has been involved in the assessment, if applicable..... ☐ **Yes** ☐ **No**

Name of Therapist	Telephone No.

VI. Certification by Therapist Completing the Assessment

Therapist's Name (Print)	License No.

Signature	Date

Resident Name:

Section D: Supplier and Item Information

Supplier's Business Name	Telephone No.
Supplier's Representative Completing Form	Fax No.
Address	City, State, ZIP Code
ACD System Name and Model Number	

Item No.	Local Medicaid Code	Description of Item	Quantity	Total Price
1				$
2				$
3				$
4				$
5				$
6				$
7				$
8				$
9				$
10				$
		Total Amount of All Items Requested		**$**

Supplier Certification and Acknowledgement

1. I certify that the services and items being supplied under this order are consistent with the ACD assessment for the resident and that the requested items are appropriate and can safely be used in the resident's environment when used as described in the ACD assessment.
2. I understand that as the supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for durable medical equipment (DME) and that as the supplier, I will not be paid more than the amount authorized.
3. I acknowledge that as the supplier, I will not seek additional reimbursement than the amount authorized. I will not seek or accept any additional payment from the provider, resident or resident's responsible party or other party for the ACD system. I also acknowledge that modifications and adjustments required within the first six months of delivery of the ACD system are covered within the authorized amount.

Supplier Representative's Signature	Date
National Provider Identifier (NPI), if Contracted Medicaid or Medicare DME Provider	

Resident Name:

Section E: Physician-Related Information/Prescription

Item No.	ICD-9 Code	Brief Diagnosis (DX)	Describe how DX is related to the medical necessity for the ACD system (if applicable).
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Resident Auditory Functionality Status Statement

Physician's Attestation of Medical Necessity for the Requested ACD System

Date resident was last seen by the physician	Duration of need for ACD system (months/years)

By signing this form, I hereby attest that the information provided in Section E is consistent with the determination of the resident's current medical necessity and prescription. By prescribing the ACD system identified in Sections C and D, I certify the prescribed ACD system is appropriate and can safely be used in the resident's environment when used as prescribed.

Physician's Signature/Attestation	Date

Physician's License No.	Physician's Texas Provider Identification No.

Resident Name:

Section F: ACD System Authorization Transfer Request and Medical Professional Attestation

I. I am formally requesting that the existing ACD system authorization for _____ be transferred from his/her previous ICF/IID provider to the provider named in Section B of this form. He/she has transferred to the new provider as of _____, and will be receiving delivery of his/her ACD system while residing at the new provider.

Printed Name of Provider Primary Contact	Signature of Provider Primary Contact	
Title of Provider Primary Contact	Telephone No.	Signature Date

II. ACD System Medical Professional Certification (The medical professional certifying the statement **must** be the resident's physician, occupational therapist, physical therapist or registered nurse.)

I certify that the services and items being supplied under this order are consistent with the ACD assessment contained in the original Form 8728 submitted for this resident and that the requested items are appropriate and can safely be used in the resident's environment when used as described in the ACD assessment.

Medical Professional's Name (Print)	Medical Professional's Title
Medical Professional's Signature	Date